STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, MAY 17, 2023

10:00 A.M.

Reported by: Ramona Cota

ALL AMERICAN REPORTING, INC.
(916) 362-2345

APPEARANCES

BOARD MEMBERS

Mary Watanabe, Acting Chair

Scott Coffin

Paul Durr

Mark Kogan, MD

Jeff Rideout, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Alma Ochoa-Soria, Associate Governmental Program Analyst

Sarah Ream, Chief Counsel

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

René Mollow, Deputy Director for Health Care Benefits and Eligibility
Department of Health Care Service

INDEX

PROCEEDINGS

10:00 a.m.

MEMBER WATANABE: Good morning. Welcome to the Financial Solvency Standards Board meeting. I think we have the public starting to join here. I am Mary Watanabe, the Director of the Department of Managed Health Care. I will just preface before we get started here, we are going to do things a little bit out of order this morning because I do have some announcements that I want to cover before we get to our typical introductions and housekeeping.

So first I want to share that I will be facilitating the meeting today. I am going to be juggling a couple of different duties today so please be patient with me; and I know the Board and our staff are going to help me make sure I do not forget anything. I do want to share that Larry deGhetaldi, our Chair and longstanding Board Member, made the decision to retire and resigned from the Board last month. Larry has served on the Board since 2010 and will be greatly missed. He has really been, in addition to just being a very nice and kind person, very supportive of me. He has brought a wealth of knowledge to the Board and our many discussions. We will miss him but wish him well in his retirement.

I am pleased and relieved to announce that Dr. Jeff Rideout has agreed to be our next Board Chair starting in August. Jeff is plenty busy with his own Board and other commitments but I really just, Jeff, I appreciate your support of both me, the Department and the Board, so look forward to getting you up to speed starting at our next meeting in August.

In addition, Scott Coffin will be retiring this month. I will let Scott share a little bit more about his plans and that announcement when we do

introductions.

But I did want to share that we will now have two vacancies on the Board and so we will be releasing a solicitation this month to fill two vacancies on the Board. So again, would ask for the Board's assistance and the public in sharing that so that we can get a good response to that solicitation.

With that, I am going to move to housekeeping items before we do introductions. I do just want to note that we have our newest Board Member that I announced last time, Dr. Mark Kogan, so, Dr. Kogan when we get to introductions, we will let you introduce yourself and tell us a little bit about your background.

So just some quick housekeeping items for our Board Members. Please remember to unmute yourselves when making a comment and mute yourself when you are not speaking. For our Board Members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item. For the attendees on the phone, if you would like to ask a question or make a comment please dial *9, state your name and the organization you are representing for the record.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or comment. To raise your hand click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment, please click Lower Hand. All questions and comments will be taken in the order of the raised hands.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with Bagley-Keene can sometimes feel inefficient and frustrating but it is essential to preserving the public's right to government transparency and accountability.

Among other things, the Bagley-Keene Act requires the FSSB meetings to be open to the public. As such, it is important that members of the FSSB refrain from emailing, texting or otherwise communicating with each other off the record during the meetings because such communication would not be open to the public and would violate the Act.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members emailed, texted or spoke with each other outside of the meetings, our public FSSB meetings, about matters within the FSSB's purview. Such communication would be impermissible, even if done asynchronously or asynchronously, such as member one emails member two, who emails member three, et cetera. Accordingly, we ask that all FSSB Members refrain from emailing or communicating with each other about FSSB matters outside the confines of a public FSSB meeting.

I did just want to give one final kind of housekeeping reminder. This will be our last meeting where the Board will be able to join virtually. So starting with our next meeting in August we will be returning to in-person meetings and the Board Members will need to attend in person. However, we will continue to have a virtual option for the public.

So that concludes our housekeeping. Now we will move on to Board introductions. Dr. Kogan would love to have you just introduce yourself

and tell us a little bit about yourself.

MEMBER KOGAN: Yes, thank you. My name is Mark Kogan. I am a practicing gastroenterologist in the East Bay in Berkeley and in San Pablo. I have been in practice since 1987. Have sort of carried a lot of different hats over the years. I have been medical director of our local IPA, been on sort of multiple different finance committees related to our IPA and other risk bearing-type organization-type stuff. Have been on the Board of the California Medical Association for about nine years and rotated off that a couple years ago. And have a great deal of interest in protecting patients' rights and, you know, assuring their access to health care. So very happy to be on the Board and hopefully will be able to contribute something here.

MEMBER WATANABE: We are excited to have you join. I will warn you that it is a lot of very technical information so please just jump in and stop us, ask questions if something does not make sense or you do not understand, we are happy to give more context and background. But welcome, welcome to the Board.

Let's see. Next, Jeff.

MEMBER RIDEOUT: Hi, this is Jeff Rideout; I am CEO of IHA. I first want to thank Mary and all the Members of this committee and staff for the trust you are putting in me to be your next Chair. We will miss Larry and I will try to keep his sense of humor going. Mark, I would like to welcome you, personally.

And I guess one thing that I did do recently, about a week and a half ago I was testifying to the US Senate Finance Committee on the topic of mental health providers and ghost networks, so that was an interesting experience as well. I do not know – it came back to a lot of provider data

accuracy issues, which I know we have worked on quite closely in the state of California. Thank you again for making me your next Chair.

MEMBER WATANABE: Thank you, Jeff.

Amy.

MEMBER YAO: This is Amy Yao, I am the Chief Actuary of Blue Shield of California.

MEMBER WATANABE: Thank you.

Paul.

MEMBER DURR: Paul Durr, CEO for Sharp Community Medical Group, an IPA in San Diego, California.

MEMBER WATANABE: Great. It looks like Scott is running a little bit late, so, Jordan, maybe if you will just ping me when Scott joins and we can pause, if we can, and have him introduce himself and talk about his retirement and what is coming next for him.

I will just quickly introduce the DMHC team. We have Sarah Ream, our Chief Counsel who will be presenting later. As always, we have Pritika Dutt, our Deputy Director for the Office of Financial Review, Michelle Yamanaka, Supervising Examiner in our Office of Financial Review. Jordan Stout who keeps all things running for our FSSB and is a manager in our Office of Financial Review. And I think maybe newer to this committee is Alma Ochoa-Soria who is providing administrative support today, so thank you, Alma.

All right, we will move on here. I see you, Scott. You are driving. Thank you for joining, Scott. Do you want to quickly introduce yourself? I did announce your retirement, so I don't know if you want to share anything else about that.

MEMBER COFFIN: Okay. Can you hear me okay?

MEMBER WATANABE: Yes.

MEMBER COFFIN: Okay, great. Hi, good morning. Yes, my name is Scott Coffin, CEO for Alameda Alliance for Health up until the end of this month, so two more weeks left. And also very much have appreciated serving on the FSSB. Thank you.

MEMBER WATANABE: Thank you, Scott.

All right. We will move on to our next agenda item, which is the transcript and meeting summary from the February 22nd meeting. I will first pause and see if there are any changes or questions about the meeting summary; otherwise, I will take a motion to approve the meeting summary.

MEMBER DURR: I will make a motion to approve.

MEMBER RIDEOUT: I will second that.

MEMBER WATANABE: Okay. All right, thank you. So with that, the meeting summary is approved.

I am going to just pause here quickly and see if we have any questions or comments from the public on any of my earlier announcements or on the meeting summary. Jordan, any public comment?

MR. STOUT: Seeing none at this time.

MEMBER WATANABE: Okay, great. All right, we will move on to our next agenda item here, which are my remarks.

I will start with the governor's May revise. The governor released his main revision to the budget last Friday. There continues to be a lot of economic and revenue uncertainty, primarily related to the debt limit impasse, higher interest rates, delayed tax receipts until October of this year, and the

potential for a recession. While we are not in a recession yet, even a moderate recession could have a significant impact on the state's budget

In January, the budget deficit was 22 billion. I think we talked about that at our last meeting. That has grown to 31.5 billion. The May revise really tries to balance the uncertainty while protecting safety net programs. I think there has been a lot of recognition of just appreciation for the work that went into really being thoughtful about protecting some of the advancements we have made, particularly around our safety net programs. I am not going to spend a lot of time on the May revise because I think the items most relevant to the Board are going to be covered in the DHCS update by René Mollow so I do not want to repeat too much of that.

I will just take a minute maybe to talk about the Distressed Hospital Loan Program. At our last meeting there was a lot of concern about distressed hospitals, particularly with the closure of Madera. I did just want to note that this week the governor signed AB 112, which creates a Distressed Hospital Loan Program, and the budget included 150 million in zero interest loans to help public and not-for-profit hospitals who are at risk of closure due to extreme financial distress. The loan program will be administered by the Department of Health Care Access and Information or HCAI. I know this is something of interest and we can certainly have HCAI talk more about the work they are doing in the space. We have been working very closely with them on the information that we have around hospitals. And as requested we are going to try to include HCAI and the Office of Health Care Affordability in our Board meetings on more of a regular cadence. So did want to just mention that because I know that is an area of interest.

One other item is at the end of March as part of the governor's kind of state of the tour roadshow, the Governor announced a series of reforms to modernize our behavioral health system. The key elements really include authorizing a general obligation bond to fund behavioral health residential setting expansion, housing for homeless veterans, modernizing the Mental Health Services Act and improving statewide accountability and access to behavioral health services. So, again, René is going to talk about a lot of this because most of it was in the Medi-Cal space.

But there was kind of a really small item related to the DMHC and commercial plans that I want to make sure the Board is tracking because we will be talking more to you probably about this over the next year. The governor's behavioral health reform proposal includes a proposal to align the behavioral health coverage requirements between the Medi-Cal program and the commercial health plans. While commercial health plans are required to cover medically necessary behavioral services, and there's a lot of similarities with Medi-Cal, there are some differences.

Enrollees in commercial plans and beneficiaries of Medi-Cal are entitled to similar coverage for mental health and substance use disorder services. But what we often hear is is what we call wraparound services and so there are some differences related to maybe intense care management, family support, navigation. So over the next year we are going to be working closely with DHCS to really identify these differences and develop a plan for achieving parity between commercial and Medi-Cal coverage, really to ensure that all Californians have access to the services they need. This may include phasing and alignment of utilization management requirements, standardizing benefits, or

covering services provided by the county. So a lot of work that will go into kind of the planning and a robust stakeholder process that will include health plans, our consumer advocates, county representatives and other system partners. I will share more information as we kind of move through this but this is a pretty big deal in terms of behavioral health reform.

So I will pause there. And I see, Jeff, you have already got your hand up so go ahead.

MEMBER RIDEOUT: A couple of related questions to the mental health item you just noted. First of all, can you comment at all on the MCO tax and the uplifting of Medi-Cal payments to providers, including mental health? And then second, would any of the benefit, I will call standardization, include some of the in-lieu-of services benefits provided through Cal-AIM and some of those programs that they were rolling out?

MEMBER WATANABE: Yes. So maybe I will let René talk about the MCO tax because I think there are some important pieces there to increase reimbursement to providers, including mental health providers, but I do not want to steal her thunder because she does have that in her presentation.

I will say in terms of the in-lieu-of-services, part of our planning is really to understand what the differences are. I think most of us that have worked in the space have heard for many, many years, there is something more that you get in the behavioral health space if you are a Medi-Cal enrollee. And I will say I am not sure we are quite clear what those are and how you would bill for that in the commercial space and so that will be part of our engagement. It could include those in-lieu-of-services, it could include, you know, reimbursing the county for the services that they are providing. So, we really want to try to

understand what those services are and so I think the first step is really doing that mapping to what is covered in the commercial space versus in Medi-Cal.

Other questions from the Board on any of my updates? Navigating hands here, Amy, go ahead.

MEMBER YAO: I have a question. Just going back to AB 112 for distressed hospitals. I know CMS just published the proposed Medicare reimbursement for hospitals and for California the increase is substantial, the trend really high compared to national or other states. So that, hopefully, will help those hospitals.

MEMBER WATANABE: Yes, no, thank you for that. I think that has been a big -- part of the conversations that we have been having too is just both the Medi-Cal and Medicare reimbursement rates and the mix of commercial versus Medicare and Medi-Cal. There's a lot of factors that go into the financial distress of hospitals including just, you know, the cost of nurses and staffing too. But appreciate that. Thank you, Amy.

Any other comments or questions from the Board before we go to the public?

All right, I am not seeing any. Jordan, do we have any questions or comments from the public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: All right. I think with that, René, we are going to go to your updates, and I have already got some questions for you, so we will take it away, René.

MS. MOLLOW: Thanks so much, Mary. Good morning, everyone. I am René Mollow, Deputy Director for Health Care Benefits and

Eligibility. So, I typically come -- it's either myself or Lindy Harrington that covers. But Lindy has now been promoted to our Assistant Medicaid Director so I will share duties with making DHCS updates with Rafael Davtian, he is now appointed as the new Health Care Financing Deputy Director for the Department. So next slide, please.

I am going to just give a brief update on the governor's May revision as it impacts the Medi-Cal program. And the one thing I will note in my presentation, and I am sure when you have had Lindy present as well, there may be some topic areas that while I am giving the presentation, I may not have all of the knowledge of the particular policy area. So if there are questions that come up that I cannot effectively respond to today, I can take those back and then do a follow-up and get answers back to your questions. But I will do my very best in terms of responding to any questions. So next slide, please.

In terms of the governor's May revise and as it relates to the DHCS. So our budget for fiscal year 2023-24 includes $156 billion in total funds for DHCS. And again, because we operate the Medicaid program as our largest program here, the funding for services under DHCS also includes federal funds and so it is approximate. It may be like a 60/40 split given the various federal matching percentages that we are able to use in our program.

The major updates to our budget include the MCO tax and provider rate increases; modernization of the behavioral health system, as Mary had referenced; and then also the renaming of the program previously referred to as the California Behavioral Health Community-Based Continuum of Care Demonstration. We are trying to be a little bit more succinct and now it is going to be called BH-CONNECT, which is Behavioral Health Community-Based

Organized Networks of Equitable Care and Treatment. Again, a long name but maybe an easier acronym to use in terms of BH-CONNECT. Next slide, please.

I think what is going to be most relevant for the Board today is the work on the MCO tax. So again, the budget does include a renewal of the Managed Care Organization tax effective April 1 of this year; and it is nine months earlier than what was originally planned in the governor's budget and with a higher tax structure. So what this tax will afford us is an additional 12.9 billion in General Fund revenue over the duration of the tax as compared to what was in the governor's budget.

So we do propose for this budget year to use revenue of 2.5 billion to achieve a balanced budget in this fiscal year.

And then the remaining funds will be used to support Medi-Cal investments over an eight to ten year period.

We do propose to make some rate increases to at least 87.5% of the Medicare rate for primary care, maternity care and non-specialty mental health services.

So in terms of managed care plans, what these rate increases will do, they will effectively eliminate the use of the AB 97 reductions and also account for Prop. 56 supplemental payments for the applicable services. We will require managed care plans to pay the providers at least the base fee-for-service rates, including in capitated provider arrangements. So for the applicable services where the rate increases will be applied we will eliminate the historical AB 97 reductions. And then we will shift the historical Prop. 56 supplemental payments into the base rate increases. So we will annually review and revise the fee-for-service reimbursement rate for applicable services based on changes to

Medicare rates. Because we do look to have our rates under Medi-Cal to that of Medicare or a percentage thereof if it is not at 100% of the Medicare rate.

And again, we will direct the managed care plans to pay the providers at least the base fee-for-service rates for provider arrangements.

These investments will support our quality strategy and the clinical focus on children's preventive care, maternal care and birth equity and behavioral health integration. And this aligns our efforts towards upward preventative and primary care interventions.

Following the submission of the tax to CMS, because we have to get this in to CMS, this request in to them, by June 30th of this year. We will then work in collaboration with key stakeholders in the Medi-Cal delivery system and will focus on enhancing equitable access to care and will assess which ongoing long-term rate augmentations will deliver the greatest benefit to improving the Medi-Cal systems in California. So we will look at additional augmentations to primary care, maternal and behavioral health services, as well as specialty care, outpatient and acute care systems. And again, looking at how these increases will lend to the commitment of providers to serve Medi-Cal members and then also support providers that are disproportionately impacted in areas where there's low reimbursement rates. And then we will also look to work where we can to help build a strong workforce to help ensure we have care in the right settings, at the right time, and with the highest quality.

So in discussions with CMS as it relates to the MCO tax, our desire to reinvest the revenue, in terms of expanding access and quality in the Medi-Cal program, has been key to CMS’s acceptance of this tax, this size. We do know that CMS has indicated that they are going to be changing federal regulations as

it relates to health care taxes and require that taxes be more proportional in their Medicaid and non-Medicaid liabilities. So we are not sure if the proposal that we have will be approvable in the future and we can't assume that future MCO taxes will provide such a high net benefit to the state. So I just wanted to share, you know, the status of this. More to come on this front in terms of the rate increases and the impact of the MCO tax.

A couple of other items to just call out.

MEMBER RIDEOUT: René? René?

MS. MOLLOW: Oh yes, I'm sorry, go ahead.

MEMBER RIDEOUT: I'm sorry, I just want to get to this question before we get away from it too much if it is all right. I apologize.

MS. MOLLOW: Oh yes, go ahead, Jeff.

MEMBER RIDEOUT: Okay. I applaud anything that increases payments to primary care physicians, maternity care and mental health specialists. Is this floor applicable to MCOs and an expectation of MCOs as well or is it a guideline or does it apply just for fee-for-service Medi-Cal? That would be one important question I have.

MS. MOLLOW: Yes, no, so just to reiterate my points. The managed care plans will be required to use the base fee-for-service rates that will establish with this 87.5% increase to their providers. So those rates will then be factored in accordingly into the cap payments that are paid to the managed care plans. But they will be directed to make sure that these rates are then passed on to the providers in their network as the base. If you go higher, you can go higher, but at least at the base it has to be at the percent that is set in the fee-for-service delivery system.

MEMBER RIDEOUT: Thank you. And one follow-up question: That we have done a fair amount of primary care spending work in the commercial side. And in addition to kind of the rate itself there is how much funding goes to primary care versus any other form of care. And that is, that is a pretty wide range. So this seems like a great opportunity to kind of level that out as well with the MCOs. Is that an intention, perhaps?

MS. MOLLOW: Yes, yes. Because what we will be looking at future forward is also looking at specialty care services and where we might then also put some focus in terms of those rate increases as well.

MEMBER RIDEOUT: Thank you.

MS. MOLLOW: You're welcome. Thanks so much for the question. So next slide, please. And my apologies, because I am looking at some of my speaker notes here and I might not follow along with changing the slides so I will just make sure I am tracking on both.

So a couple of other key investments in terms of the DHCS budget is there is also the $40 million to begin modernization of the behavioral health system.

And so the three focus areas are around the Mental Health Services Act reforms, the accountability and access to behavioral health services, and then a general obligation bond to establish the Behavioral Health Infrastructure Act and Grant Program.

There is going to be a lot that will be coming out from the Department in terms of the modernization of the behavioral health system and so more to come on that front. I know we have put out some general information, but over time more and more information will be coming out and then where

there may be impacts to the managed care plans. Right now, this is really focused on the work that is being done with county behavioral health in terms of specialty mental health services; but there will also be work that we will be looking at as it relates to mild to moderate services as well. So more to come on that front, especially based upon the comments that Mary had made earlier. Next slide please.

There is also $6 billion over five years to implement the BH-CONNECT effective January 1 of 2024 and we will be seeking a federal waiver for this demonstration during the summer. And there will also be a workforce initiative that is directed towards strengthening that pipeline of behavioral health professionals. Next slide, please.

And I will get to, Jeff, you had had a question about some in-lieu-of-services. When I talk about community support and ECM I will then touch on your question at that point.

In terms of the other big component part of our budget is about the coverage expansions for undoc individuals. So the budget does maintain the funding in the budget of 1.4 billion, which is equivalent to 1.2 billion of General Fund for the budget year and then 3.4 billion total funds, 3.1 billion General Fund, at full implementation. This is inclusive of in-home supportive service costs for doing the Medicaid expansion for individuals without satisfactory immigration status, ages 26 to 49.

We do expect that there will be approximately 700,000 individuals that will be impacted by this policy and the policy will be operational no sooner than January 1 of 2024. It is important to note that that 700,000 individuals, what we are calling out are those individuals that are currently enrolled in the Medi-Cal

program that have been identified as being in restricted scope due to their unsatisfactory immigration status through similar processes as what we have done for other transitions of this nature. We will then work to transition individuals into full scope coverage. We will do the same outreach that we do with them in terms of informing them about their coverage options. This population will be moving into managed care based upon the respective counties that they reside in and so they will have the options to pick from managed care plans based upon the counties where there are options for the managed care delivery system.

I also want to note that as of March of this year we have approximately 340,000 individuals that were enrolled under the Older Adults Expansion. When we first rolled this out we had had lower estimates, but there has been an uptick in terms of the number of people that have been identified that have been afforded this benefit coverage policy under the Medi-Cal program. Next slide, please.

So before I go there, were there any questions about the budget updates? If that is okay for me to ask Mary? I should have asked about process.

MEMBER WATANABE: Yes, no, of course and I appreciate you taking questions in-between your presentation. Paul, go ahead.

MEMBER DURR: Yes, no, René, it is a great presentation and thank you for that. You know, I cannot help but think about it is great that the Medi-Cal reimbursements are kind of getting up to where Medicare is but, you know, I do worry about the consistency about being able to sustain the increases that are being put on the pressures of our, our independent doctors in the

community with labor rate increases, you know, if the minimum wage goes into effect, the 25. We hope that there's more thought around that. But, you know, my point is, is that the increases for labor and supply costs in our physician offices, the Medi-Cal rates and Medicare rates are not keeping pace with that so it is going to further exasperate the tenuousness of our provider network as well as the expansion of, you know, the undocumented, which I support. But it is just we need to make sure that the reimbursement rates are kind of keeping pace with the cost pressures. And I know there is nothing -- it just a comment and I applaud moving in that direction. But just being aware that as we forecast further out, the need to get those rates higher, closer to Medicare and up further.

MS. MOLLOW: Yes, no, thanks for that, Paul, really appreciate that. And I think we are, you know, looking at ways in which we can be, you know, as thoughtful and considerate as we can within the, you know, the constraints that we have for the program, recognizing the size and capacity of this program. So I do appreciate those, those comments, so thank you.

Okay, so then I will now give a brief update on our unwinding efforts.

MEMBER WATANABE: René?

MS. MOLLOW: Oh, yes, I'm sorry.

MEMBER WATANABE: Sorry. We do have one more hand; Dr. Kogan had his hand up.

MS. MOLLOW: Oh, thank you.

MEMBER WATANABE: Sorry.

MS. MOLLOW: Ah-ha.

MEMBER WATANABE: Go ahead, Dr. Kogan. Oh, you are on

mute.

MEMBER KOGAN: Yes, got it. I'm sorry. Actually, that was semi-accidental. But I was going to sort of reiterate what Paul had said is there's, you know, even at those rates for people in private practice with, you know, inflation and everything else, it is impossible to see those patients and not lose money. You know, I realize, again, it is a systemwide problem. But, you know, in terms of maintaining access for patients it's just, it's a huge issue.

MS. MOLLOW: Thanks. And do understand that. I think, you know, one of the considerations, it's not the, it's not the solution. But it's also looking at the provider networks that we are using in the program. So looking at both the licensed professional providers as well as say our unlicensed providers such as community health workers, the use of doulas, paraprofessionals, that participate in our program. So, I mean, we are looking across the board at that in terms of, you know, requirements and the things that we can do, policies that we can effectuate that can help make, you know, lessen some of that pressure on the licensed providers. But again, recognizing there is a need for the collective group of individual entities to participate in this program to help meet the needs of the populations that we are serving. So do appreciate the comments. Are there any other questions before I go to the next topic?

MEMBER WATANABE: I don't see -- go ahead, Scott.

MEMBER COFFIN: Hi, René. This is Scott, Alameda Alliance. I have a question in regards to, and you may have mentioned it. I know it is part of the undocumented adults, older adults 26 to 49. But the Department of Health Care Services had announced last year that the movement or the transition of Medi-Cal beneficiaries in the fee-for-service system, that about 99% would be

transitioned over to managed care by the end of calendar year '23. Is that still on track?

MS. MOLLOW: Yes. So what will happen, Scott, is with the coverage expansion of the 26 to 49 come January 1 of 2024, essentially 99% of our population will be in managed care delivery systems. So that population when they get transitioned over, there will be a select group of individuals if they are in a County Organized Health System on January 1, they will be enrolled in that County Organized Health System. And then prior to that, based upon the outreach work that we do, if the individuals have made their plan selections prior to January 1, then those plans selections will be effectuated. Otherwise, the managed care plans will see those enrollments occurring, say, by February. So those individuals that we will be covering through the coverage expansion, that is what will then kind of push us up to that threshold of 99%. Because that is a pretty big chunk of individuals in our program. And chunk is probably not the best word. But it is a good proportion of the individuals that are still residing in our fee-for-service delivery system. So come January 1, everyone in the Medicaid program will have full scope services. And again, based upon their circumstances, the majority of those people will be required to be in managed care delivery systems. There are still those populations that will be carved out or have the ability to remain in fee-for-service. But again, we are estimating it will be a 99% managed care, a 1% fee-for-service. And then you have the new people coming in over time. But yes, that is what we are estimating.

MEMBER COFFIN: Okay. Thank you, René.

MS. MOLLOW: Ah-ha, you're welcome. Any other hands? I can't see the hands.

MEMBER WATANABE: I know. I am not seeing any. Maybe going once, going twice from the Board any questions?

All right, why don't you keep going, René.

MS. MOLLOW: Okay, very good. So next slide, please.

So just wanted to let you know that we are in the throes of the unwinding of the continuous coverage requirements. We resumed doing the redeterminations as of April of this year, and those were resumptions will be for individuals with a June redetermination month, because we kind of back things up by about 75 days in terms of starting renewals. So, plans would start to see the impacts of the renewals with the July enrollment files that you are going to be receiving from the Department. So, if members have not been redetermined via ex parte, meaning we have the ability to look at information in the files that are available to our county partners, they will use that information to do the redetermination and then confer continuing eligibility.

If people are not able to be redetermined, either because of loss of contact or they truly are no longer eligible for Medi-Cal, then they will be disenrolled from our program.

And we will also be working closely, you know, for those plans that are part of Covered California, for individuals that lose coverage, as a result of the Senate Bill 260. There will be individuals that will be moved over into Covered California automatically. But again, to effectuate that coverage, members would not have to at least pay their premiums for that coverage to continue by moving over to Covered California. But that is when the plans will start to see the impacts of the redetermination. Next slide, please.

So in terms of the continuous coverage unwinding, just wanted to

share a little bit about our work in terms of helping to reach out to our Medi-Cal members in terms of helping them to do -- helping them to maintain their coverage. The biggest thing for them is making sure that they have updated contact information as well as responding to the request for renewal information if they happen to get that request from the county partners.

So we have done an email/texting campaign, that started the week of May 8.

We also have an enhanced landing page for KeepMediCalCoverage.org. So we have enhanced that page for people to, you know, understand what they need to do to remain covered.

We have paid advertisement that is live statewide in 19 languages across digital, radio and out of home platforms.

And then we have some new State Covered/Take Care of videos in various timeframes that are now available for partner use him as part of the unwinding toolkits that we have developed.

And again, the materials are in all of the threshold languages for the Medi-Cal program. What will be key, and we have been working very closely with the managed care plans, in terms of being able to obtain a updated contact information from the members and then sharing that information with our county partners. And then also the state is looking at, you know, additional ways in which we can support the managed care plans by making information available to them on renewal dates for individuals so that it is an all hands on deck approach in terms of supporting our members and making sure that those individuals that are truly eligible for this program retain that eligibility for coverage.

The big thing for people to be mindful of is to look for the yellow envelope. So as you can see on these little, the little yellow squares, you will see the person and the mailbox and you will see in their hand a little yellow envelope. That is our big message is that if people are receiving a yellow envelope, they need to take action because that means the county was not able to automatically renew their coverage so they will need to take action. And that action can be in various forms, it is not just one pathway to update that information. Next slide, please.

The other thing about the unwinding that is really important is that we are going to be publishing data on a monthly basis in terms of the outputs of the unwinding efforts. So we will be looking at total enrollment. We will also be looking at applications and a snapshot of people being determined eligible or ineligible, applications that are pending, applications received. There will also be information on the redetermination and a high-level snapshot of what we are seeing in terms of the numbers that were due for redeterminations and then the numbers that were identified as no longer maintaining their Medi-Cal eligibility. Along with the top five reasons for discontinuances. And we will be publishing the dashboard starting in August for the June 2023 benefit month.

And we do have a website where we will be posting this information and we will also be posting the information that we have to submit to the federal government. Because for each month of the unwinding there are some specific data that has to go to CMS and we will be reporting that as well as sharing that on the DHCS websites. So I will stop there to see if there's any questions regarding the coverage unwinding.

MEMBER COFFIN: Hey, René, this is Scott.

MS. MOLLOW: Mm-hmm.

MEMBER COFFIN: I have a question in regards to some information that the Department of Health Care Services shared, I think it was last year or a prior year, that about 18% of the Medi-Cal beneficiaries, we do not have correct addresses for them. So, my question is --

MEMBER WATANABE: Scott, you cut out, can you repeat that? Scott, we can't hear you.

MEMBER COFFIN: If there is a situation where there is a beneficiary where we don't have the correct address, will they be disenrolled or are there going to be other considerations taken by the -- my apologies. Can you hear me okay now?

MEMBER WATANABE: Yes.

MEMBER COFFIN: Okay.

MEMBER WATANABE: You were cutting out a little bit, Scott. Maybe try repeating that or René may be able to piece together what we heard.

MS. MOLLOW: I think so.

MEMBER COFFIN: All right. Can you hear me?

MS. MOLLOW: Yes, I think so. I can, Scott. I think I heard, I think I got the gist of what you were asking so I am going to try to respond to you.

MEMBER COFFIN: Okay, thanks.

MS. MOLLOW: And you let me know if I didn't cover it in totality. So last year when the Department had done an outreach just to start informing people about the unwinding and the need to make sure that they have updated contact information and to share that information, at that point in time we had gotten a 12% returned mail for that population we had outreached to. So when

the Department reaches out to individuals that is about -- we will send letters out to the heads of households. So we sent out about 9 million pieces of mail. So we got about 12% of that returned.

With our current efforts and all the work that has been done with our coverage ambassadors, with our health and moment navigators, our managed care plans, people on the ground helping to support this effort, we did another mailing in April to now tell people, like, it is really important to update your contact information and then to also respond to the request for information from the county partners. We are just now starting to see the impacts of the return mail and right now the numbers are lower than what we were seeing before. I don't know that we have the full totality of that impact right now but we are seeing that it is slower. That is where we got our initial estimates of people that may lose their coverage because of loss of contact and that is where we were estimating the 2.3, maybe 3 million individuals will lose coverage.

The important thing to note about Medi-Cal renewals is that when someone is identified as being discontinued and they have, you know, their Notice of Action that will say, you know, as of this date you have lost coverage, they have up to 90 days to get that information back to the counties if they have not gotten it back to them during that, you know, initial period when the county had reached out to them. So if they, in fact, do lose their coverage they have up to 90 days where we have what we call the -- oh, now the word just escaped me but it is like a reconsideration period. And what can happen is during that 90 day period, if they get that information back to the county, then the county can, you know, act on that information, confirm eligibility, and then reestablish their eligibility back to the day in which -- or back to the month in which they had lost

their coverage. So they will be held harmless during that time period and it will be like their coverage was continuous. So we do have that 90 day time period.

If they do not get the information back to us during that reconsideration period then they would have to file a new Medi-Cal application to come back into coverage. And again, you know, Medi-Cal application processing when it is a clean application, and all counties have up to 45 days to confer eligibility. But we do have that reconsideration period for individuals if, in fact, they had lost coverage and had not responded during that window in time before the coverage was actually ended.

The other thing to note is, we are required through the unwinding efforts and just part of our normal policies, but as we are doing the redeterminations and when the counties are starting to do their outreach for individuals, they also have to make another form of contact. So mail is one and then they can call people, text people, email people about reminding them to get the information in if they have to get information back to the county. Typically, the information that the county needs is updated income information because that is usually what will determine that they are ineligible for the program. So during that 60 to 90 day -- the 60 to 75 day window, the counties will also be contacting them to get that information. So there's multiple touches that are occurring prior to that actual notice going out discontinuance for individuals. Did I cover what you had questions about Scott?

MEMBER COFFIN: Yes you did, René, thanks.

MS. MOLLOW: You're welcome, thank you.

Any other hands?

MEMBER WATANABE: I am not seeing any, René, so why don't

you continue.

MS. MOLLOW: Okay, very good. And so on this next one on the CalAIM updates I am going to kind of breeze through this one because I just wanted to give some highlights in terms of some for the work that we are doing as it relates to Enhanced Care Management and community support updates. So next slide, please.

This again -- and you all have this information in your packet so I am not going to, like, go through all of this information. But just as a reminder, Enhanced Care Management and Community Supports, they became operational in January of 2022. These are benefits that are required under or that are provided through the managed care delivery system, so Enhanced Care Management is a managed care benefit. That Community Supports help to address the social drivers of health and managed care plans are encouraged but not required to provide community support services. And these are alternative services that can be cost-effective alternatives to help individuals who may have a need for services such as hospital base or skilled nursing facility services for these individuals. But if there is an option of services that managed care plans can select from in terms of the community supports.

I think it was, it wasn't Scott. Now I can't -- it was Jeff, I think, who had asked the question about community supports or in-lieu-of-services. So originally it was in-lieu-of-services, we renamed it to something that is a little bit more digestible as community supports. Those services are optional through managed care plans. It's under our CalAIM waiver. And one of the things that the Department will be doing is assessing the array of services and supports that the managed care plans are selecting. And over time we will be making

evaluations about the community supports, what is being provided, and of those supports what services might we move over to our state plan as a required benefit in the Medi-Cal program at large. But right now, the managed care plans are encouraged but not required to provide these services and supports and Medi-Cal beneficiaries also have the option of receiving these services or supports based upon what the managed care plans do provide. So I hope, Jeff, that that answers your question about the in-lieu-of/community support services and how we are looking to address those services in the Medi-Cal program.

MEMBER RIDEOUT: Yes, it does, René, and thank you for renaming Community Supports, I like that.

I had read recently that given this is an optional program for MCOs, that, at least for the highest or the most popular services, like over well over 90% of the MCOs in the counties they operate had created these community support options for beneficiaries; is that correct? Like housing navigation was a big one and there were a few others.

MS. MOLLOW: I am going to give you a slide on that.

MEMBER RIDEOUT: Okay.

MS. MOLLOW: To show where we are at with that, and it is just the point you are making. Will also help inform us in terms of what we can seek federal approval for to add as a state plan benefit, future fold.

MEMBER RIDEOUT: Okay, thank you.

MS. MOLLOW: So next slide, please.

This just gives an overview of what ECM is. Next slide, please.

In terms of the populations of focus for enhanced community -- for Enhanced Care Management, this just gives a snapshot of what happened when

the benefit went live. And then the populations of focus that are upcoming this summer and at the beginning of the year. So this is just a snapshot of the communities of focus that the plans are using for purposes of the Enhanced Care Management. Next slide, please.

This is just a slide on the community supports and the array of community support services that can be provided by the managed care plans. And again, the plans have the ability to select, you know, one or more of these services. Next slide, please.

So in terms of an overview, this slide just shares where we are at with the Enhanced Care Management services since year one of implementation. So again, the start in January of this year and this just kind of gives a snapshot of where we are at in terms of the provision of Enhanced Care Management and Community Supports. The Department also released a fact sheet on the use of these services in support and so this kind of provides populations of focus and then the services. Next slide, please.

And again, this is another slide that gives an overview of the community support and the populations that are covered by the community support services. And again, there was a fact sheet that was released on these services and supports. Next slide, please.

So again, one of the things that the Department has been doing is listening to the feedback from the community on Enhanced Care Management and Community Support. So there has been statewide listening tours that our Director and our State Medicaid Director and staff have been going out and listening to the community, including our plans in terms of what we are hearing about the use of these services and supports through the Medi-Cal program. It

includes feedback through our advisory groups that we host, through surveys, interviews, data that we receive from the managed care plans, as well as the listening tours that we are undertaking. Next slide, please.

Based upon the feedback that we have received, these are some of the areas where we are going to be providing some policy guidance and clarifications in terms of the feedback that we have heard regarding Enhanced Care Management and Community Support. So I just wanted to share this in terms of some areas that are going to be upcoming in terms of policy guidance from the Department, again, based upon the feedback we have received through those various venues.

Are there any questions at this point in time on the Enhanced Care Management or Community Supports? Okay, very good.

MEMBER WATANABE: I am not seeing any hands, René.

MS. MOLLOW: Okay, very good. I am not going to touch on the PATH, you all have the information in your slide deck, because I want to be mindful of time. But PATH is Providing Access and Transforming Health updates. So there are some slides here that kind of give a definition of what PATH is, the funding availability that we have. There are initiatives under PATH that are being supported. While managed care plans are not recipients of these dollars, there's infrastructure building that is happening at a local level that can then help the managed care plans as they are doing their work in terms of Enhanced Care Management and Community Support. So next slide, please.

This just gives an update of the funding that is available. Next slide.

These are the various initiatives under the PATH program. Next

slide, please.

And then the next four slides just cover those topic areas that were identified or the initiative areas under PATH. So again, I am not going to directly go through these slides but you do have the information. If there are questions that you all have regarding PATH you can contact the Department regarding the work that we do under PATH. Okay.

So the last thing I just wanted to touch on was the Justice-Involved Initiative. That is a big component of the work that we are doing under the 1115 Waiver. Wanted to let folks know because I know the managed care plans have had extensive engagement with the Department relative to the Justice-Involved Initiative under CalAIM. And this just gives a high-level overview of the status of some guidance that will be forthcoming.

So we are going to be releasing guidance on the policy and operations guide for stakeholder feedback. This is the timeline for when we are going to release the draft, when we are expecting feedback to come back to us, and then when we will finalize this operational guide, the policy and operational guide for the Justice-Involved Initiative. There will be guidance that goes out to our county partners, to our behavioral health partners and to our plan partners. And again as a reminder, for the Justice-Involved Initiative and the actual delivery of services, the pre-release services will not be offered until starting April 1 of 2024 and then it can be phased in between April 1 of 2024 through March 31 of 2026. But correctional facilities may wait until March 31, 2026 to go live. But again, there will be an opportunity based upon the readiness state of the correctional facilities in terms of making available the prerelease services. Next slide, please.

This, again, just provides some guidelines in terms of additional policy guidance that will be coming out for the managed care plans specifically, as it relates to the Justice-Involved Initiative. So it is important, you know, for the plans to be aware. And there is a significant amount of communication that is going out to let them know about their roles and responsibilities and their understanding of the policies and procedures that we are putting out for this initiative.

And with that, those are my updates from the Department Health Care Services and I welcome any questions that the Board may have at this time.

MEMBER WATANABE: Thank you, René.

Any questions from the Board? Amy, go ahead.

MEMBER YAO: Yes. Mary, thank you. It is a really stupid question. What is Justice-Involved Services? I don't recall I heard that.

MS. MOLLOW: Oh, no, not a problem, Amy, and thank you for the question. So the Justice-Involved Services, we have an ability to provide a set of services, Medi-Cal-covered services, in correctional settings, both at the state level as well as at the jail level. So they are Medi-Cal covered services. And we have looked at -- and in the materials that you will receive for the plans to review, there is information on what those array of services look like. So, it's covered benefits under Medi-Cal. It can include, you know, like lab, X-ray services, visits with providers, whether it's primary care, specialty care, enhanced care management services. It can also include pharmacy services and the receipt of DME. DME would be provided, you know, like once someone is getting ready to transition into the community. But the goal here is to make sure we are able to

provide an array of services and support that the person will need once they transition from the correctional setting. And then doing a warm handoff whether it's to, you know, based upon the needs of the person, both to the managed care plan as well as to our behavioral health network of providers.

MEMBER YAO: Thank you.

MS. MOLLOW: You're welcome.

MEMBER WATANABE: Any other questions from the Board before we go to public comment?

All right, I am seeing none.

Jordan, do we have any public comment?

MR. STOUT: None at this time.

MEMBER WATANABE: All right. Well, René, as always, we appreciate you and the very comprehensive presentation. I don't know if you are able to stick around but we have our financial summary of the Medi-Cal managed care plans coming up next. So, thank you, appreciate your time today.

MS. MOLLOW: Thank you so much. I do have to leave. But if questions do come up later on in your agenda please do not hesitate to reach out.

MEMBER WATANABE: Absolutely. We will follow up with you or Rafael. Thank you again.

MS. MOLLOW: Thank you so much. You all take care now. Bye-bye.

MEMBER WATANABE: Thank you, René.

All right, Pritika, Financial Summary of Medi-Cal Managed Care Plans.

MS. DUTT: Thank you, Mary.

Good morning, everyone. I am Pritika Dutt, I am the Deputy Director for the Office of Financial Review at the DMHC. I will provide you a quick update on the Financial Summary of Medi-Cal Managed Care Plans, 4th Quarter ended December 31, 2022. A copy of the report is available on our public website under the Financial Solvency Standards Board section.

This report is prepared by the DMHC on a quarterly basis and highlights enrollment and financial information for Local Initiatives, County Organized Health Systems and Non-Governmental Medi-Cal plans. The Non-Governmental Medi-Cal plans, or as we refer to it as NGMs, because we are using a lot of acronyms today. So NGM plans are plans that have more than 50% Medi-Cal enrollment, but they are not a Local Initiative or a COHS.

The report is divided into three distinct areas, first focusing on Local Initiatives, then COHS and NGM plans. Next slide.

There are 9 Local Initiative plans that serve over 6.4 million Medi-Cal beneficiaries in 13 counties. Total enrollment increased by 1.7% compared to the previous quarter. All LIs reported an increase in enrollment. LA Care is the largest Local Initiative plan with 2.6 million enrollees and experienced a 1.6% enrollment growth over the last quarter. Overall, the LI plans' Medi-Cal enrollment increased by almost 111,000 members from September 2022 to December 2022.

The medical expenses slightly increased from September 2022 to December 2022.

And then for the quarter ended December 31, 2022, the LIs reported total net income of $121 million.

All LIs met the DMHC's reserve requirement for tangible net equity requirement, or TNE. TNE to required TNE for the LIs ranged from 573% to 1,413%. Next slide.

There are 6 County Organized Health Systems plans that serve 22 counties. We receive financial reports from 5 COHS. Gold Coast does not report to the DMHC. The 5 COHS that report to the DMHC serve 2.4 million Medi-Cal beneficiaries as of December 31, 2022. All COHS experienced enrollment growth for the last six quarters. CalOptima and Partnership Health Plan reported the highest enrollment numbers. Compared to the prior quarter, COHS plans' Medi-Cal enrollment increased by 25,000 lives.

For the fourth quarter of 2022 the COHS reported total net income of $138 million. All COHS plans reported net income.

And then all COHS plans reported over 666% of required TNE, so TNE to required TNE ranged from 666% to 1,482%.

There are 8 Non-Governmental Medi-Cal Plans that serve 4 million Medi-Cal beneficiaries in 37 counties. All NGM plans reported an increase in Medi-Cal enrollment in December 2022 except UnitedHealthcare Community Plan. For the fourth quarter of 2022 NGM plans reported total net income of $409 million. TNE to required TNE ranged from 255% to 1,251%.

All Medi-Cal managed care plans reported increases in Medi-Cal enrollment since the first quarter of 2020 and through the pandemic, largely due to the suspension of the annual Medi-Cal redetermination requirement during the public health emergency or PHE. The Medi-Cal redetermination will resume on April 1, or resumed already on April 1 of 2023, with the first disenrollments from coverage occurring in July, which would more likely contribute to decreases in

enrollment and revenues for Medi-Cal managed care plans starting with the second half of 2023.

Additionally, the DMHC is working with DHCS on the implementation of CalAIM, the California Advancing and Innovating Medi-Cal, and also on the Medi-Cal re-procurement to assess the financial impact of the changes on the Medi-Cal managed care plans.

The Medi-Cal managed care plans continue to meet or significantly exceed the minimum TNE requirement. And the DMHC will continue to monitor the enrollment trends and financial solvency of all Medi-Cal managed care plans.

With that, I will take any questions.

MEMBER WATANABE: Any questions from the Board? Dr. Kogan, go ahead.

MEMBER KOGAN: Yes, thank you. With the, you know, anticipated disenrollment of about 2 million members, have we specifically looked at how that is going to impact the cash flow for a lot of these, you know, the county health systems and all of them? Is that anticipated to be a problem?

MS. DUTT: We are looking closely at the financials right now; all the plans have adequate reserves. So, you know, as you noticed, a lot of the plans have over 600% of TNE, at least 500% of TNE. So we are looking at their reserve levels. Working closely with DHCS and watching the trends. So nothing concrete yet because we don't have the exact numbers, but we are anticipating changes in revenues and expenses cash flows. So we will be working closely with the health plans that fall under the DMHC.

MEMBER WATANABE: And I will just add, I think that is something we will be monitoring very closely throughout this year and having further

conversations likely with the Board as we, as we see how this all plays out.

MEMBER RIDEOUT: Mary?

MEMBER WATANABE: Jeff.

MEMBER RIDEOUT: Mary, to kind of pile on to what Mark was saying, you know, a lot of these trends, if they keep going, do not line up very well. So you have got, you know, enrollment down, you have got net income down, you have got MCO, taxes going up, you have got primary care physicians still not paid enough to want to stay in the game. Is there -- and Pritika, this might be asking too much but it seems more than kind of looking at it. It is almost like we need to kind of prospectively model it a little bit like as scenarios for what happens if the trend lines continue, scenarios for membership loss. Is that something the Department could reasonably do as part of what we would be discussing? I know TNE is fine but it is a very late indicator of financial stability it seems like.

MS. DUTT: Jeff, we can take it back and look at the data that we have and maybe try to see -- something that we have discussed with Mary is we are thinking about changing this report to incorporate some of the changes that are going to happen in Medi-Cal for 1/1/2024. So just parsing out, you know, into three different buckets may not work in the future. So we are looking at this report and seeing how we can make changes in the future and making, incorporating additional information and making it more informative. So if you have any feedback you can always send us an email and we can incorporate some of the changes in the report.

MEMBER RIDEOUT: Yes, I think most of our organizations usually go through some sort of reforecasting process and with scenario planning. Even

René's comments about, well, these are optional benefits, but they may become permanent. Well, that is going to have cost implications as well. So, I think there's a lot of maybe basic things we could put into that kind of reforecast and say, this is what it could look like going forward.

MEMBER WATANABE: Other questions from the Board?

All right, I am not seeing any. Jordan, do we have any questions or comments from the public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: Okay, all right. Well, thank you, Pritika, I know you will be back in a few minutes.

Let's go to Sarah Ream for a federal update.

MS. REAM: Good morning, everybody. I am Sarah Ream; I am the Chief Counsel for the DMHC. This morning I am going to be providing some updates regarding four different items at the federal level that we are tracking.

So first, I will touch just very briefly on the impact of the end of the federal public health emergency, next I am going to be talking about a federal regulation that we are tracking, and then finally I am going to touch upon two federal cases that are currently making their way through the courts.

So with respect to the end of the public health emergency For COVID-19, I am not going to spend too much time on this because I talked about it at the last FSSB meeting and also because for at least the short term for the next six months it does not have any particular impacts on California enrollees. So those enrollees can still access COVID testing, immunizations, therapeutics, in or out of network with no-cost sharing.

Six months from the end of the federal PHE, so in November,

enrollees will be or they may be subject to cost-sharing if they access those services out of network, but plans will still need to cover the services. The end of the PHE does impact the amount that health plans must reimburse non-contracted providers and that takes effect immediately. So between now and May 12, plans must reimburse out-of-network providers at 125%. They must reimburse them at least. There is no cap on the amount, they can go as high as they want to, but the minimum is 125% of what Medicare pays for the service. This is in contrast to under the CARES Act and the FFCRA plans were required to pay the providers' posted cash price. So now it is 125% of Medicare. Beginning November 12, out-of-network reimbursement drops down to 100% of Medicare so there is there is sort of a step-down there.

We are working on some comprehensive guidance regarding the impact of the end of the public health emergency on California plans, enrollees and providers. We are going to be issuing that in the coming weeks so please keep an eye out for that.

Turning next to a proposed regulation that we are following at the federal level. HHS recently proposed changes to the HIPAA privacy rule to limit certain disclosures of information related to reproductive health. The change, if it is enacted, would prohibit a HIPAA-regulated entity, so a health plan, an insurer, providers, and those sorts of entities, from using or disclosing a patient's PHI for the purpose of criminal, civil or administrative investigation, or proceedings brought because the patient received or sought reproductive health care under certain circumstances. So these circumstances include when reproductive health care services were provided outside of the state where the investigation or proceeding is authorized, and the health care services are lawful in the state

where they were provided.

So an example of this would be if a patient in Texas were to come to California for a lawful abortion and then someone in Texas tried to sue the California doctor alleging that that doctor violated Texas abortion restrictions. So in that instance, any HIPAA-regulated entities in California would be prohibited by this regulation from providing information regarding the patient's abortion and related services, so they would not be able to disclose that information. The modified rule would also prohibit a HIPAA-regulated entity from using or disclosing an individual's PHI for the purpose of identifying an individual health care provider or any other person for the purpose of initiating an investigation or proceeding against the individual or the health care provider or the person in connection with reproductive health care, if it was -- if the health care was rendered in a circumstance where it was lawful to do so.

So this is really targeted at a concern that in some states where abortion has been outlawed, or severely restricted, that those states or people in those states may be trying to reach into other states to prosecute individuals or providers who are providing reproductive health care services.

So the comment period for this regulation is open until June 16 and if you are interested you can go and read more about it on the regulations.gov website. So this is one we are tracking quite closely.

Finally, two federal cases that we are tracking.

The first is *Braidwood Management v. Becerra*. In this case in March, a Texas federal district court struck down part of the ACA that requires coverage with no-cost-sharing of preventive services recommended by the US Preventive Services Task Force. The Texas court in this case also held that the

ACA's requirement to cover prep medications to prevent HIV violated the religious rights of the plaintiffs in the case. So this case does not directly impact California health plans or enrollees because California law has an independent requirement that plans cover preventive services with no cost-sharing. However, the ruling could impact those Californians who are in self-insured products because they are not subject to the Knox-Keene Act. They are subject to the ACA; they are not subject to the Knox-Keene Act. However, in breaking news, yesterday the Fifth Circuit Court of Appeals issued an administrative stay in the case. That stay prevents the Texas court's ruling from taking effect until the Fifth Circuit considers it more fully. So for now that ACA requirement for preventive services remains in effect nationwide.

The second case we are tracking is *Alliance for Hippocratic Medicine v. FDA*. So this is the case involving mifepristone, the abortion drug. And unlike the *Braidwood Management* case I just discussed, this case could have significant impacts for California enrollees, health plans and providers, have nationwide impact. So this is the case, another one out of Texas. In this case the plaintiffs are challenging the FDA's original approval of the abortion drug mifepristone that was granted back in 2000 and they are also challenging subsequent FDA approvals related to mifepristone.

The recent history of this case is somewhat convoluted. You may have been following it in the news. But the short story is that for the time being mifepristone is available nationwide, or at least in those states where abortion is legal. And it does not require an in-person visit to be prescribed or dispensed; instead it can be prescribed and dispensed via mail. So please bear with me for a second. I am going to just describe in brief the convoluted history of this case

and provide some insight into where we are now and where we might go.

So in early April, the Texas district court judge issued a preliminary injunction and ruled that in 2000 the FDA had improperly approved mifepristone. The judge's order, if it were allowed to stand, would have effectively blocked that approval of mifepristone and would have resulted in immediate removal of the drug from the market.

However, the judge delayed the effective date of his decision by a couple of days to allow the FDA to appeal to the Fifth Circuit Court of Appeals, which they did right away. The Fifth Circuit then issued an order, a complicated order that allowed the original approval of mifepristone to stand. But it rolled back subsequent FDA actions regarding mifepristone. So if the Fifth Circuit Court of Appeals' decision were in place, mifepristone would be available where abortion is legal, but the generic would not be available, patients would have to meet in-person with a provider to get a prescription for mifepristone, and mifepristone would not be able to be dispensed via mail. So it kept the approval in place but really rolled back the clock fairly significantly.

So the FDA and the other defendants in the case then went to the Supreme Court for an emergency appeal. And on April 21st, the Supreme Court blocked the district court total removal of mifepristone, so blocked that order in its entirety, and it sent the case back to the Fifth Circuit, which is where we are now. So the case, so for the time being mifepristone is available, like I said, nationwide, but this case is far from far from over. And in fact, today the Fifth Circuit, probably right at this moment, is hearing arguments regarding mifepristone and whether the preliminary injunction that the lower court had ordered should move forward or whether, you know, it should be denied or where

that should go. So this is really a case that is in pretty significant flux right now and we are following it very closely.

And that is it for my presentation. I am happy to take questions.

MEMBER WATANABE: Amy.

MEMBER YAO: Yes, I have a question. Sarah, thanks for the update but my question is not related to what you talked about. My question, I don't know if this is something you could answer. So right now there's lots of discussions about the federal government's debt ceiling and what the decision is going to be. So what will be the implications for the Medi-Cal, potentially Medicare, or even the ACA government payments, you know, the subsidy payments and Medicare payments. Do you have any point of view on that?

MS. REAM: Amy, I'm sorry, you were breaking up a little bit. Are you asking about if the --

MEMBER YAO: The federal debt ceiling. What will --

MEMBER WATANABE: The debt ceiling conversations.

MS. REAM: Oh, my gosh. If you mean if we don't pass the debt ceiling. I think there's going to be a lot of problems, is all I can say. I mean, I am not speaking here as an attorney for the Department, I am speaking as a citizen of what I, you know, heard on the radio and the news. I think that many payments for all sorts of Social Security, Medicare, Medi-Cal, everything would come potentially to a grinding halt so it could be very, very, very significant.

MEMBER WATANABE: Yes, I would agree. I don't think we fully know other than it could have a significant impact on a number of programs, borrowing. Yes. There's others on here that may have thoughts on what the impact would be but it is probably the biggest uncertainty as we think just even

about our state budget and programs here.

MS. REAM: I would (indiscernible) as horrible.

MEMBER WATANABE: Yes, yes. Jeff, you probably have thoughts on this.

MEMBER RIDEOUT: I have thoughts but nothing intelligent to add other than I (overlapping).

MEMBER WATANABE: Nothing to share publicly?

MEMBER RIDEOUT: Yes. Sarah, I had maybe a slightly more practical question. You could follow, your group could follow any number of federal pieces of legislation. Can you give us a little sense of which ones you choose to follow? And I was struck by this testimony I gave a couple of weeks ago that the provisions, it's Senate Bill 5093, are very, very similar to state AB 236. So, you know, I don't know if that qualifies as something to follow or whether that is, you know, just sort of curious.

MS. REAM: No, it's an excellent question. I mean, I think the starting point, we were tracking activity at the federal level all the time. But what we really want to hone in on are things that will impact California enrollees first and foremost, providers and plans. What is interesting is oftentimes we will see California – I mean, I think AB 72 from some years ago, surprise balance billing. So we will have a California law that is enacted and then some years later the federal government steps in and they pushed forward a bill that largely follows what California has already done. So we will track those bills. We will make sure that we are, you know, we are paying attention to it because there may be nuances to the federal bill that could impact enrollees. But oftentimes I feel like California is at the – we are the vanguard and then the rest of the nation,

sometimes follows, does or does not follow along. I guess that would be -- first and foremost it is what is going to directly impact California enrollees and providers and plans.

MEMBER WATANABE: And Jeff, maybe I will just add. When we have pending legislation we are in a little bit of a tricky position where we typically don't discuss those here at FSSB until we have things that are more final. I will just say generally, as you know, all things provider directories, ghost networks, are very hot issue right now so we are tracking all of that very closely. We have had discussions both at the federal level with other states on the work that we have done here, obviously, with Symphony, and SB 137, the work we do to review network adequacy. So those are things we follow very, very closely. But until there is something more tangible to share we have, you know, final legislation within the state here. Then, obviously, we will have more conversations about that in future Board meetings, if that helps any.

MEMBER RIDEOUT: Yes, it does. As an editorial comment, I can at least say the anger directed at ghost networks was bipartisan.

MEMBER WATANABE: That is not surprising. It is a huge access issue. And we talk all the time. Access to care and timely access to care is really at the core of the consumer protections and, you know, at the forefront of everybody's mind when you think about what you are getting for the health care premium that you pay every month, so I am not surprised at all.

Other questions for Sarah from the Board before we take public comment?

Thank you, Sarah, there's a lot, a lot going on.

All right, Jordan, do we have any questions or comments from the

public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: All right. Well, speaking of health care premiums, Pritika, you are up to tell us what's happening on premiums and prescription drug costs.

MS. DUTT: Thank you, Mary. So a lot has been going on in the rates and prescription drug cost reporting world.

I will go over our findings from the 2022 large group, small group and individual market annual rate filings, and also highlight some of the key findings from the last *Prescription Drug Cost Transparency Report* for measurement year 2021. So all these reports were issued towards the end of 2022 and the beginning of 2023.

The DMHC has issued three reports that include more detailed information on the filings and these reports are included as part of the meeting materials available on the DMHC's website. So if you look at the materials, the links to these reports are available there.

The large group health plans must file aggregate rate information and specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs annually.

The DMHC is required to conduct a public meeting in every even-numbered year to permit a public discussion regarding changes in the rates, benefits, cost-sharing and other factors in the large group market.

The information we are discussing today is for groups that renewed during calendar year 2022.

Twenty-three plans were required to file and that includes eight

statewide plans so these are plans that offer products in many different regions, ten regional plans that mainly offered products in one or two regions, and then five local health plans that have In-Home Supportive Services Plans for their IHSS workers.

Almost 7.9 million enrollees were in large group plans licensed by the DMHC.

The large group rate increased by 4.1% on average, with the average premium per enrollee of $552 in the large group market.

Health plans are also required to include information in their notices to employers that compares the rate change to those in Covered California, CalPERS and then the average rate increase in the large group market.

Covered California and CalPERS negotiate rates with the plans similar to large group employers so it gives some comparison to large employers when they are ready to negotiate rates.

You can see the average rate increases for calendar years 2018 - 2023.

I want to highlight that the spike for 2018 Covered California rate increase is due to the Cost Sharing Reduction surcharge that was included in the 2018 Silver plan rates due to the lack of federal government funding of CSR subsidies.

Excluding this surcharge, the 2018 statewide average increase for Covered California plans was about 12.3%.

This chart shows the average premium per member per month by year from 2017 through 2022.

The average premiums for statewide plans have consistently been

lower compared to regional plans.

The average premium continues to rise every year, which is consistent with the renewal increases shown on a prior slide.

This chart shows the average rate increases for 2017 through 2022.

Aside from 2019, over the most recent four-year period, the average increase for regional plans have been much lower than their statewide counterparts.

However, as seen on the previous slide, the average premium was lower for the statewide plans compared to the regional plans.

The average rate increase was 4.1% for all large group plans. The average monthly premium was $552.

We are showing Kaiser separately here since Kaiser represents the majority of the enrollment in the large group market with about 66%.

Kaiser reported an average increase of 3.6%, with an average premium of $542.

This table shows the average rate increase, enrollment and monthly premium by product type.

In 2022, PPO and POS plans had the highest premium, with an average premium of just over $600 per member per month.

Overall, HMO plans experienced the second lowest average rate increases with a 3.9% increase and had the second lowest average premium of $545 per member per month.

This table shows the number of covered lives by actuarial value. An actuarial value is the percentage of total average cost for public health care

services that are paid by the health plan. For example, if a plan has an actuarial value of 70%, on average an individual would be responsible for 30% of the costs for all covered health care services and then the health care service plan would be responsible for 70 percent of that cost. Plans with a higher actuarial value are generally considered to have richer benefits with lower cost-sharing when enrollees access public services. 81% of large group enrollees or 6.4 million were in HMO plans with actuarial values rated at 80%, and therefore the richest of benefits overall. In contrast, HDHP, which is high deductible health plans, tend to give members lower premiums, but then when members go get services their out-of-pocket costs are significantly higher.

Assembly Bill 731 expanded the rate review practice that the state already has in place.

A large group contractholder that has coverage that meets specific criteria can request the DMHC to review a rate change if the contractholder makes the request within 60 days of receipt of their rate change notice.

A large group contractholder may request the DMHC for a review of a rate change from a health plan licensed by the DMHC.

Please visit the DMHC website to request a rate review or if you are interested in getting more information on the process. Next slide.

Now I will discuss the small group and individual market rates.

In 2020, California enacted Assembly Bill 2118 for the purpose of increasing transparency of rates in the individual and small group markets.

AB 2118 requires health plans that offer commercial products in the individual and small group markets to report specified information, including premiums, cost-sharing, enrollment, and trend factors to the DMHC annually.

The DMHC is required to annually present the reported information at various meetings, as specified, and post the reports on the DMHC's website no later than December 15 of each year.

In this next section we will summarize the aggregate rate information and weighted average rate increase on health plan premiums for small group coverage in measurement year 2022 and compare information for on-exchange, off-exchange and grandfathered products.

The DMHC received small group aggregate rate filings from 14 health plans for measurement year 2022, including 7 statewide plans and 7 regional plans. In 2022, 2.25 million enrollees had small group coverage with a DMHC plan.

This table compares information between on-exchange, off-exchange and grandfathered products.

Small group plans that offered on-exchange products covered 78,000 enrollees and had an average increase of 3.5% with an average premium of $533.

Off-exchange plans covered almost 2 million enrollees and had an average rate increase of 3.4% with an average premium of $562.

And then grandfathered plans covered 156,000 enrollees and had an average rate increase of 3.7% with an average premium of $527. And then grandfathered products are those products that were pre-ACA but they were in existence prior to the Affordable Care Act.

Overall, the average rate for small group plans increased by 3.4% and the average premium across all health plans was $558.

Next I will summarize the aggregate rate information and weighted

average rate changes on health plan premiums for individual coverage in measurement year 2022.

For measurement year 2022, the DMHC received individual market aggregate rate filings from 12 health plans, including four statewide plans and eight regional plans. The 12 individual plans covered 2.4million enrollees.

This table here compares information between grandfathered and on- and off-exchange plans. Overall, the average monthly premium in the individual market was $562, which was an increase of 1.5% from 2021.

Eleven health plans offered on-exchange products and covered 1.8 million enrollees with an average premium of $567.

Eleven plans offered off-exchange products and covered almost 510,000 enrollees with an average premium of $535.

Only two plans offered grandfathered plans and covered 48,000 lives with an average premium of $653.

The next two slides look at enrollment by Metal Tier for on- and off-exchange plans.

Of the approximately 2.4 million enrollees in the individual market, 1.8 million enrollees purchased on-exchange products or products sold by Covered California.

The majority of enrollees selected silver plans, which is one of the four metal tiers of coverage.

About 70% of the enrollees were in silver or higher metal tiers in the individual market for both on- and off-exchange plans.

The majority of enrollees in the individual market chose HMO plans with higher actuarial value. And again, the higher actuarial value plans represent

richer benefits.

High deductible health care plans had the lowest enrollment for both on- and off-exchange plans and provided members a lower premium option with higher out-of-pocket costs, actually.

Catastrophic health care plans offer coverage in times of emergencies as well as coverage for preventive care. Catastrophic health plans typically come with low monthly premiums and a high deductible.

This next slide shows the enrollment by metal tier for off-exchange plans. Approximately 570,000 enrollees represent the off-exchange plans.

Now I will quickly summarize the *Prescription Drug Cost Transparency Report for Measurement Year 2021*.

In 2017, California enacted SB 17 with the purpose of increasing transparency of prescription drug costs.

SB 17 requires health plans that file rate information with the DMHC to report specific data related to prescription drug costs. In addition, it also requires drug manufacturers to provide advance notification of significant prescription drug cost increases and makes public certain information associated with these increases to the Department of Health Care Access and Information or HCAI.

SB 17 requires the DMHC to issue an annual report that summarizes how prescription drug costs impact health plan premiums.

Health plans must report to the DMHC information about their 25 most frequently prescribed drugs, 25 most costly drugs by total annual spending, and 25 drugs with the highest year-over-year increase in total annual spending.

Some of the key findings from the report include:

Health plans spent more than $10.8 billion for prescription drugs in 2021, which was an increase of $700 million from 2020 and it was an increase of $2.1 billion since 2017. That was the first year we started collecting information.

Prescription drugs accounted for 13.3% of total health plan premiums in 2021.

Health plans' prescription drug costs increased by 6.6% in 2021, whereas medical expenses increased by 9.2%.

Overall, total health plan premiums increased by 2.2% from 2020 to 2021 and that includes all markets, individual, small group and large group.

Manufacturer drug rebates totaled approximately $1.6 billion in 2021. And this represents about 15.5% of the $10.8 billion spent on prescription drugs in 2021.

While specialty drugs accounted for only 1.6% of all prescription drugs dispensed, they accounted for 62.9% of total annual spending on prescription drugs.

Generic drugs accounted for 88.2% of all prescribed drugs but only 16.3% of the total annual spending on prescription drug costs.

And that brings me to the end of my presentation. Any questions?

MEMBER WATANABE: I know that was a lot of information. Thank you, Pritika. Paul, go ahead.

MEMBER DURR: Yes, no, Pritika, it was very good. You know, I can't help but think about the average rate increase for the large group that you were talking about and noticing how the HMO has the lowest increase overall, I think it was 3%. I think it speaks to what Jeff has demonstrated through IHA and the value equation of HMO and a coordinated care model and that it does help

improve not only cost efficiency but the quality of care. So that always stands out to me and I think that is a great thing.

The only other comment I have is with regards to the prescription drug piece and noticed the comment about the specialty pharmacy and certainly, again, I will bring up what's missing is the medical side. That the providers are having to bear the cost of what seemed to be on not the prescription side but on what is done within physician offices and that growing cost and the impact to our providers. Somehow, I am hoping that we would be able to get to getting that information connected in there somehow because it is really a driving concern for us on the provider side. Thank you.

MS. DUTT: Thank you, Paul.

MEMBER WATANABE: Amy.

MEMBER YAO: Yes. I have one ask and one comment. What I want to ask is on the large group rate pharmacy, the biggest share and trend differences between the national pharm and the regional pharm is we get to see the national pharm's trend actually went down in the individual plan. I'm wondering if you showed the same deal for small business and individual? Are we going to see a similar kind of gap? If we do, I am kind of curious where the regional plan has a lower trend. So that's one kind of ask.

And my comment is on your prescription trends you shared a .41. You showed the drug trend is like 6.6% and the medical trend is 1.2%. On the surface, it looks like the medical service is driving the rate increase and trend. But I do think it is probably not the case because 2021 is a very special year. It is a lot of medical services rebounding from the low point of 2020. So it would be interesting to compare pharmacy versus medical trend, maybe using some other

years for that. You know, there were plans back when the pharmacy trend was a much bigger problem than (inaudible).

MEMBER WATANABE: Pritika, do we in the small and individual market report, do we break out the statewide versus regional?

MS. DUTT: We do in the report. It does not have a similar chart. But if you go and -- I was opening the report.

MEMBER WATANABE: Yes.

MS. DUTT: If you look at, I think Table 4 and Table 5 for the individual side, that will show you. If you open up the report it will show you, you know, the regional and statewide for the individual market. And similarly, there is tables in the report that shows you regional and statewide.

MEMBER YAO: Thank you.

MEMBER WATANABE: And just for the Board, I think Jordan when we sent the materials sent a link to the report. And for the public, these are, if you go to our website, there is a Reports link on the right, and you can find a link to these reports as well.

MS. DUTT: But, Amy, if you are suggesting that we put a slide in the presentation next year, we can include one. We just tried to condense the slides because there were a lot of slides, so we tried to shrink it down. But we are happy to include it next time.

MEMBER WATANABE: Jeff.

MEMBER RIDEOUT: Pritika, great work, as always and I will echo what Paul and Amy said. It is, again, interesting to note that with low-ish premium increases, they are definitely outpaced by both drug and medical costs and that can’t go on forever. So I guess, you know, one thing maybe on just the

presentation would be if we had just a trend of medical cost, of pharmacy cost, of general inflation, and of premium cost for the individual market segments, I think that would jump off the page quite a bit. And, you know, at some point something has got to give. We keep saying that. And I think right now it is a lot of the provider community that is suffering or bearing some of these adverse costs but you have got to also credit the plans for holding the line on a lot of the specialty drug costs, too. So it is, you know, everybody is working hard but I don't know how long it keeps going.

MEMBER WATANABE: Yes, that is good feedback. And obviously, we will be getting individual market rates here in July so I think towards the second half of the year we will be talking more, particularly about the individual market. Any other --

MEMBER RIDEOUT: It is interesting to note over the years, you know, I remember, you know, I am feeling older all the time. But there was such a gap between, you know, large group rates and small group and individual, then, of course, Covered California standardized a lot of that. But it is interesting how they are converging in terms of rate increases, really, at least so it seems.

MEMBER WATANABE: I would agree, Jeff. I keep -- we have been doing these reports, particularly on the individual and small group side, for quite a while and so I, you know. I always talk, you know, the average rate premium rate is getting close to, you know, 500. And now I am like, I keep saying we are getting close to 600.

MEMBER RIDEOUT: Yes.

MEMBER WATANABE: But we are seeing more alignment across the market segments. Pritika, anything else you want to add or respond to any of

the comments?

MS. DUTT: No. But we will go back and see what data we have available. Those are good feedback and we will try to incorporate that in the future slides. And I want to thank the DMHC actuaries for doing a fabulous job on these three reports every year. They do look at a lot of data from the plans so I want to give them a shout-out here.

MEMBER WATANABE: There is a wealth of information in each of these reports. As Pritika mentioned, we have summarized it here, but for those that have time and an interest, would refer you to the full reports for a lot of information.

Any other questions from the Board before we go to public comment?

All right, seeing none, Jordan, do we have any hands up from the public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: Okay. Bill Barcellona is not with us today, so we do not have a lot of public comment. (Laughter.)

All right, let's move on. Michelle Yamanaka, Provider Solvency Update.

MS. YAMANAKA: Hello, good morning, almost good afternoon. I am going to give an update on the RBO financial reporting for the quarter ended December 31, 2022.

For the quarter ended December ’22 we have 210 RBOs reporting to the Department. This includes two new RBOs that began reporting this quarter and we have 22 RBOs on CAPs.

For the financial reporting the RBOs are required to submit annual financial reports, which are due 150 days after the RBO's fiscal year end. We received 20 reports for the fiscal year ends March, June and September of 2022. The majority of the RBOs have a fiscal year end of December 31 and those are due at the end of this month by May 31 so those are coming in as we speak.

We also receive monthly reports from RBOs that are on corrective action plans to continue monitoring them to ensure that they are on track with meeting their milestones on their approved CAPs. Next slide please.

For the financial reports, there are 188 RBOs or 90% of the RBOs that are reporting compliance with all grading criteria. Of the 180 there are 9 RBOs on our monitor closely list, and we have 22 RBOs that are on corrective action plans for non-compliance with one or more of the grading criteria.

Moving on to the corrective action plans. Again, 22 RBOs. Two RBOs have two corrective action plans that we are monitoring, so it brings our total count to 24 CAPs that we were reviewing. Of the 24, 22 are continuing from the previous reporting period and 2 are new. Of those 22 continuing, 8 are meeting their milestones and are improving and 4 did not meet, were not on track with their approved projections. For additional information regarding the corrective action plans we have an attachment, a handout which includes – and it is sorted by the management services organization or MSO. The attachment includes the MSO if the RBO is contracted with them. The contracted health plans, enrollments, enrollment information, the quarter the CAP was initiated, compliance with the approved CAP and the grading criteria deficiencies. After our December 31 review, we were able to complete several of the CAPs, 14 in total. Of those 14, 10 RBOs are compliant with all grading criteria and 4 RBOs'

accounts were deactivated and are no longer accepting risk from health plans.

Moving on to the grading criteria, let's start with TNE. We compiled the data for -- next slide please. We compiled the data for December 31, quarter ended December 31 and we used the TNE and the required TNE to calculate this ratio. RBOs reporting less than 100% TNE to required TNE were below the grading criteria requirement. At December 31, 136 or 65% of RBOs had TNE in excess of 500% and 3 RBOs reported non-compliant with the TNE grading criteria. Two of the 3 had less than 10,000 lives assigned to them and one RBO had approximately 10,000 to 25,000, in that range of enrollment.

Moving on to working capital. We calculated the relative working capital by using the current assets, excluding current affiliate receivables, and to current liabilities. This slide shows the number of times the current assets covers the current liabilities. At December 31, over 98% of the RBOs were able to cover their current liabilities, with a ratio of 1.0 or higher. There were 3 RBOs that were reporting non-compliance with the working capital grading criteria.

Moving on to cash-to-claims ratio. The cash-to-claims ratio is calculated by taking the RBO’s cash, HMO capitation receivables collectable within 30 days, over the current total claims liability. The minimum requirement is .75. This slide represents the cash-to-claims ratio at December 31. A majority of the RBOs had sufficient cash reserves to cover their total claims liability. And there were 4 RBOs that reported less than .75 and did not meet the grading criteria requirement. Next slide please.

And the last grading criteria is the claims timeliness ratio. This slide shows that a majority of the RBOs are reporting compliance with a 95% claims timeliness ratio and 4 RBOs reported non-compliance.

Moving on to enrollment. This slide represents the enrollment at December 31, which is captured from the quarterly survey reports that the RBOs submit. There's approximately 9.2 million enrollees assigned to the 210 RBOs. This is an increase of approximately 63,000 enrollees from the previous reporting period and we continue to see the increases in the Medi-Cal and Medicare population.

Looking specifically at the Medi-Cal enrollment, we captured the RBOs that had Medi-Cal lives assigned to them. There were approximately 5.5 Medi-Cal lives assigned to 85 RBOs. This represents approximately 59% of the total lives assigned to the 210 RBOs. Of the 85 RBOs, 66 had no financial concerns, 6 were on our monitor closely list, and 13 RBOs, were on a corrective action plan.

Taking the top 20 RBOs, a majority of the Medi-Cal lives, which is approximately 4.1 million lives assigned to the 20 RBOs, 12 RBOs had no financial concerns, 3 RBOs were on our monitor closely list and 5 RBOs were on corrective action plans. Of those 5, 4 of those have been completed subsequent to the 12/31 review.

And that does it for my update for the provider solvency at December 31 and happy to take any questions.

MEMBER WATANABE: Any questions, first from the Board? Go ahead, Paul.

MEMBER DURR: Michelle, no question but just a comment that it is great to see the improvement, significant improvement on the RBOs as well as your last statement with regards to the Medi-Cal. That there is the improvement in the 3 out of 5, I think you said, so great to see that things are improving so I

just wanted to comment.

MS. YAMANAKA: Thank you. We are happy as well.

MEMBER WATANABE: Thank you, Paul. Dr. Kogan.

MEMBER KOGAN: Yes, thank you. I apologize but some of this may be educational for me. I have the opposite question. It looks like there are several plans on there that have been deficient for multiple quarters, are not really improving under their corrective action plan, what happens to those plans?

MEMBER WATANABE: You're on mute, Michelle.

MS. YAMANAKA: Sorry about that. We have had several corrective action plans. At December 31, 4 of them were not meeting their approved projections. Of those, 2 of those corrective action plans, which dealt with claims timeliness, we extended the timeframe for 2 of the RBOs to obtain compliance. And the other 2, those 2 accounts have been deactivated where the RBOs is no longer taking any risk. Of those 2 that were deactivated, they had less than 10,000 lives assigned to them. So the majority of them are improving. We did complete 10 out of the 24 so next quarter we will not see those RBOs Because we completed their corrective action plans. So in the sense of monitoring and reviewing, a majority are improving from the previous reporting periods.

And in the sense, to answer your question, in the sense that we see an RBO is not improving, our first goal is try to work with the RBO as well as their contracted health plans to see what need to do. We might ask for revised projections that need to be approved, because it is a collaborative effort between the RBO, the contracting health plans and the Department. So our first, our first goal is to try to work with the RBO to see if they, if there is something that they

can do to improve their deficiencies.

Our last resort is we can freeze the enrollment. So where the RBO is no longer able to accept additional or cannot take additional enrollment until they cure their deficiencies or provide a plan to show improvement and how they are going to do it.

And the last option is to de-delegate, which they can no longer take additional risk.

So those are the available options that we have for the RBOs who are in financial distress and need additional assistance. Does that answer your question?

MEMBER KOGAN: Yes, it does, thank you.

MS. YAMANAKA: Okay, sure.

MEMBER WATANABE: All right. Other questions from the Board?

All right, seeing none, Jordan, do we have any questions or comments from the public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: Okay. All right. Well, thank you.

We are going to move on to Pritika and our last item, the Health Plan Quarterly Update.

MS. DUTT: Thank you, Mary. Good afternoon, everyone.

The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended December 31, 2022. All licensed health plans are required to submit quarterly and annual financial statements with the DMHC. Additionally, we get monthly financial statements from plans who are either newly licensed, their TNE or tangible net equity falls below 150% of

required TNE, or if we have financial concerns with the health plan we place them on monthly reporting as well.

We also included a handout that shows the enrollment at December 31, 2022 by line of business and TNE for five consecutive quarters from 12/31/2021 to 12/31/2022 for all licensed health plans. And the information broken into three categories, full service, restricted full service and specialized.

As of April 7, 2023, that is the day we puled the information together, we had 142 licensed health plans. We are currently reviewing 10 applications for licensure, 5 full service and 5 specialized. Of the 5 full service, one is looking for a Medicare Advantage license where they can contract directly with CMS, 3 are looking for a license to operate as restricted Medicare Advantage plans where they would act as subcontractors to health plans that are directly contracted with CMS, and 1 is seeking a license to operate as a Medi-Cal managed care plan. For the 5 specialized plans, 3 are looking to get licensed for Employee Assistance Program or EAP and 2 are looking to get licensed as dental health plans.

Since the last meeting we licensed two health plans. One is Community Family Care Health Plan, which was licensed as a Restricted Medi-Cal plan. And then Alignment Health Advantage Plan was licensed as a Medicare Advantage health plan.

And then one plan surrendered since the last meeting. The plan was Innovative Integrated Health Community Plans. It was licensed originally to operate as a Medicare Advantage plan but they surrendered the license.

At December 31, 2022, there were 29.73 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes

HMO, PPO/EPO and Medicare supplement. As you can see on the table, compared to the previous quarter, total full service enrollment increased by approximately 188,000 enrollees. Next slide.

This chart shows the enrollment trend since 2018 for commercial and government enrollment for the DMHC-licensed health plans. The gap between commercial and government enrollment widened until 2019; and in 2020, government enrollment surpassed commercial enrollment. This was due to the steady increase in Medi-Cal enrollment during the pandemic and the suspension of Medi-Cal redetermination. Next slide.

This slide shows the makeup of the HMO enrollment by market type. HMO enrollment in all markets remained relatively consistent compared to previous quarters. Large group HMO enrollment decreased by 13,000 lives and individual enrollment decreased by 36,000 lives.

This slide shows the makeup of the PPO/EPO enrollment. There were 2.88 million enrollees in PPO/EPO products regulated by the DMHC.

This table here shows the government enrollment, which is Medi-Cal and Medicare. Overall, the government enrollment increased and the majority of the increase is driven by Medi-Cal, which increased by 210,000 lives just for this last quarter. So again, government enrollment experienced significant growth, which has led to Medi-Cal growth, since 2020.

There were about 3.84 million enrollees enrolled in closely monitored full service plans. Of the 28 closely monitored full service plans, 13 are restricted licensees and had 272,000 enrollees. And the total enrollment for the 4 specialized plans was 284,000 lives.

So we place plans on – you know, we monitor plans closely for

various reasons, to include, you know, a large influx in their enrollment whether it increases or decreases, if they are extending into additional counties, if we have financial concerns, if they are newly licensed. They could be watched more closely as a health plan for various reasons so it is not necessarily all driven by financial issue such as TNE, we could have a claims-processing issue as well.

Three health plans did not meet the DMHC's minimum reserve requirement or the TNE, tangible net equity, requirement.

The first one is Bay Area Accountable Care Network, Inc. So the plan TNE deficiency for quarter ended December 31, 2022. The plan received funding from its shareholders in February and their TNE deficiency has cured. So they are compliant, they will be compliant on their March 31 quarterly financials.

And then next is Brandman Health Plan. Brandman is a Medicare Advantage plan. They do not any enrollment. They have reported TNE deficiency since April 30 of 2022. The plan remains TNE deficient. We are working with the plan and getting updates on what they are doing to cure their deficiencies.

And then next is Medcore Health Plan. As a result of the Plan's year ended December 31, 2021 audited report adjustments, the plan was TNE deficient starting with December 31, 2021 and all the way through December 31, 2022. The plan remains TNE deficient as of this time and we are working with the Plan on getting a corrective action plan and having conversations on how they plan on remedying their TNE deficiency.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE are specialized

health plans. And again, this is because the required TNE is higher for full service health plans because medical expenses or risk is higher for full service plans; so the requirement for full service health plans is higher in terms of required TNE.

This chart shows the TNE of full service plans by enrollment category. 61 health plans, or over half of the total licensed full service health plans, reported TNE of over 250% of required TNE. If the plan's TNE falls below 150% of TNE they are required to file monthly reports with the DMHC. So you can see there are 10 plans with lower than 150% of required TNE.

This chart shows the breakdown of the 25 full service plans in the 150% to 250% of TNE range. Again, as I mentioned earlier, if a plan's TNE falls below 150% the plan is placed on monthly reporting. And we also monitor the health plans closely if we observe a declining trend in their financial performance. Which is not only TNE; we also look at net income and enrollment. If we see changes in enrollment and they become trends we also start watching them closely.

And this chart shows the TNE of full service plans by quarter. This chart pretty much summarizes the handout that was provided with the presentation. If you need detailed information on a health plan's TNE levels you can refer to the handout. Next slide.

We also added a couple of extra slides this quarter. One of them is the working capital for full service plans. This shows the dollar amount, but I will be transitioning to more the ratio format so you can see as compared to the plan's liabilities, how much assets they have on hand. So the working capital is calculated by deducting current liabilities from current assets. So what it

measures is the ability of the health plans to cover their short-term obligations. So those obligations or liabilities that are due within a year's time. It measures the plan's liquidity and short-term financial health. So here we can see 18 of the health plans have working capital below $1 million. So again, a high TNE does not equate to working capital because then a lot of the plan's assets would be tied in property and equipment, which cannot easily be translated into cash.

This chart shows the cash-to-claims ratio for full service health plans by enrollment. Unlike RBOs where they are required to maintain a cash-to-claims ratio of 0.75, there is no specific requirement for health plans. Again, like I said, we do monitor the plans to make sure they are liquid, they have the ability to pay their claims and the providers timely and ensure ongoing services for enrollees. So this measures the ability of the health plans to pay their claims. As you can see, 26 health plans reported cash-to-claim of less than 1.00, meaning they have more claims than the cash they have. But they could have assets, long-term assets, or investments that could be converted to cover their claims. Okay, next slide.

So that brings me to the end of the presentation. I will take any questions.

MEMBER WATANABE: We have got a couple of hands up already. Jeff, why don't you start.

MEMBER RIDEOUT: Another good report, Pritika, and thank you for both the cash-to-claim and working capital. Is the Department doing any specific monitoring of those that are in those lower left categories and do you collect anything like accounts payable information at the same time in terms of downstream payment to providers and others?

MS. DUTT: So the financial statements we get from health plans are very detailed. In addition to your standard report we also have a lot of schedules. Our team looks at, does a lot of comparative analysis between, you know, prior financials, the current, and looking at various trends such as comparing them to how their peer plans perform. So if there's concerns we do get additional information from the plans such as aging schedules. This is something else we look at when we conduct financial examinations.

MEMBER RIDEOUT: And personally, having sat through all the TNE presentations, this is much more interesting to me and I think it is something that we could actually maybe dig into. And I don't know about the rules on exposing who is in that category or trends or whatever, but this seems to get at the heart of solvency in a way that we haven't really gotten to before, so would love to see more of this.

MS. DUTT: Jeff, the health plans' financial statements are publicly available so they don't have the similar confidentiality requirement the RBOs do. So we can look in this, you know, the handout we have, we can add additional criteria in there to provide more information to the Board and to the public.

MEMBER RIDEOUT: Thank you.

MEMBER WATANABE: Amy.

MEMBER YAO: I have a question. Thanks, Pritika. I have a question for like, say, a national product that does business in California, are we monitoring their California segment, you know, financial situation? The reason I am asking, for example, Oscar just announced, right, that they will exit Covered California next year, so that could create a disruption in California. Did we have early warning signs knowing that they were not -- if they had financial troubles in

California, (indiscernible) in California?

MS. DUTT: Amy, like I said, we do get a lot of financial information from plans. And I think Oscar is probably on monthly reporting as well so we are getting their financial statements and we can pinpoint like who is having, you know, continued net losses, so we do see that in the financial statements. We do have early-on conversations with the different regulators if we see, if we have concerning trends. And then we also see the parent company at the national level, right? So if we have plans that are reporting to the DMHC, licensed by the DMHC, if they have publicly traded plans the information is publicly available. We do review those to see if there is funding available if the plan needs it. If not, then we do ask questions around that.

MEMBER WATANABE: Jeff.

MEMBER RIDEOUT: Yes, just a follow-up question. Do we get the same level of reporting from the RBOs and could you create similar working capital or cash-to-claims reports especially for the distressed RBOs?

MS. DUTT: Jeff, for RBOs their information is confidential. We are providing whatever we can. There is some information available on the public website on the RBOs relative to TNE. But going into like that much detail, the information is confidential. So we will take it back and look at it, what we can provide. Maybe we can just provide a link to what is available in the public website where you can see that. But we will take that back.

MEMBER RIDEOUT: Yes. And again, I am not trying to suggest we become punitive or something like that. It is just that, you know, the charter of this committee, if you go back to its history if I understand it right, was to make sure that capitated groups and plans remained solvent under the Knox-Keene

law. So, you know, it is one of those things where this is the kind of information that can give, at least as a committee member, some better visibility to that. But it is not about being punitive, we do not have that authority, obviously, but it is about understanding what is going on. It is pretty hard to sell a building these days, you know, if you, if you need cash.

MEMBER WATANABE: And Jeff, I will just note, there is a bill this year that would bring more transparency to the RB financials, so we will be tracking to see where that goes because that could change what would be available. I will just, you know, kudos to Pritika and her team. Having sat in these Board meetings for now over eight years, I am really impressed with how far our reporting has evolved and we have been very responsive to the Board's requests to look at the data in different ways. So I agree, I think moving away from just strictly looking at TNE has been really helpful so thank you to Pritika and her team for that.

Any other questions from the Board before we move on?

All right, seeing none, Jordan, do we have any questions or comments from the public?

MR. STOUT: There are none at this time.

MEMBER WATANABE: All right. So that is the end of our presentations. We will quickly move through our final items here.

This is an opportunity for the public to comment or ask questions on anything that maybe was not on the agenda or was not raised earlier. So I will pause and just see if we have any questions or comments from the public that they want to raise at this time. Anything, Jordan?

MR. STOUT: Seeing none.

MEMBER WATANABE: Okay. The next item is Agenda Items for Future Meetings. I do just want to note that at our last meeting there were a number of suggestions that we have not forgotten. But given some of the changes and the amount of content we had today we did not want to squeeze too much into this. I will just note there was a request, again, for periodic updates from Covered California as well as HCAI. So we do want to make sure that we get them into our kind of regular cadence of rotation. A request for the Office of Medicare Innovation and Integration at DHCS to present Medicare and Medi-Cal, dual eligibles and some of the challenges the and providers are having there.

And then, Jeff, you had offered to do a presentation on quality measures across the four government entities and imputed race and ethnicity. So if that offer still stands I think there would be a lot of interest in putting that into an agenda item, probably for the second half of this year. So just wanted to make sure we are tracking those. Jeff, any interest in doing that still?

MEMBER RIDEOUT: Oh, yes.

MEMBER WATANABE: Okay.

MEMBER RIDEOUT: Will be happy to do it. But later is better, as always, but will be happy to do it.

MEMBER WATANABE: Okay. So maybe we will think, maybe not August but the last meeting, I believe it is November, so we will tentatively slate that for November.

So, Scott, other items?

MEMBER COFFIN: Hi, Director Watanabe, can you hear me okay?

MEMBER WATANABE: I can, yes.

MEMBER COFFIN: Okay, good. I'm not sure what's going on with the reception, I am down here in downtown Los Angeles. I think it would be helpful for the committee, maybe at the next meeting, to understand the effect of the Kaiser Permanente direct contract and how it impacts the tangible net equity for the organizations that Kaiser contracts with.

MEMBER WATANABE: Got it, okay. Thank you, Scott. I will just note, we are going to miss you and appreciate all of your time and participation on the Board. I am sure you will still be tracking some of the things we are doing, I would guess.

MEMBER COFFIN: I will. I have learned a tremendous amount about how DMHC really oversees the financials; and of course, that is where our longstanding relationship with DMHC and some of the perils we were in once upon a time in Alameda Alliance. I think it has just helped to, to really solidify the need for oversight and controls so this is really good, so thank you.

MEMBER WATANABE: Thank you, Scott.

Other items from the Board?

Okay, you do not have to have -- we have got quite a list to work on in addition to just our regular reporting. I will, just to Scott's comment, I think between the Kaiser transition as well as the contracting changes that will take effect in 2024. Pritika mentioned we are going to think about how to maybe restructure our financial report related to the Medi-Cal managed care plans and make sure we are bringing some of those changes to these Board meetings, so more to come on that as well. All right, so --

MEMBER RIDEOUT: Mary?

MEMBER WATANABE: Yes, go ahead, Jeff.

MEMBER RIDEOUT: Just on the HCAI request. I would prefer if we lean toward OCA type of updates.

MEMBER WATANABE: Yes.

MEMBER RIDEOUT: I think that was what other people were looking for, but maybe not.

MEMBER WATANABE: Yes, no, absolutely. Hospital closures was another item that was flagged so we potentially could see if they can include an update on kind of their loan program for distressed hospitals too. But appreciate -- I think with the OCA board now meeting quite frequently we will want to hear more about what is going on there, so thank you.

Okay, I think the last item is just Closing Remarks. Thank you again for joining for the great dialogue, as always. Just a reminder, our next meeting is August 16 and we will be meeting in our Sacramento downtown office on our fifth floor. Again for Board Members, if you want to participate you will need to join us in person but we will have a virtual option for the public.

So with that, any last closing remarks anybody from the Board wants to make? Otherwise we will conclude.

Okay, hearing none, Jeff, I am happy to turn over facilitation duties to you in August and thank you again and we will see you all soon.

(The meeting was adjourned at 12:27 p.m.)

.

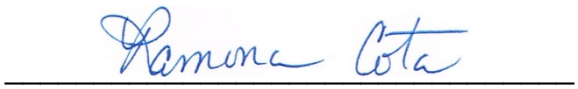
CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me, and I thereafter transcribed it.

I further certify that I am not counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of May, 2023.



RAMONA COTA, CERT*478

.